Case Management Action Plan

Introduction

The purpose of a Case Management Action Plan is to form a bridge from the assessment to the actual delivery of services. The case manager develops the Action Plan with the individual receiving services, caregiver, and/or family member. Issues and goals, as well as plans/strategies for achieving the goals are worked out together. The Action Plan provides a written summary of the issues/goals, plans/strategies, responsible person(s), and target dates for completion of the plans/strategies.

Action Plans will be completed with individuals with complex case management needs that extend beyond advocacy and benefits counseling.

A. How does the Action Plan benefit my client?

1. The Action Plan can assist the client to better understand the plan and who is responsible for carrying out each part of the plan. It can be a plan to which the client can refer. This enables the client to review the plan and agreements that have been made.

B. How does the Action Plan benefit the case manager?

1. The Action Plan can assist the case manager in reviewing what the over-all issues and plan were at the time of assessment/reassessment.
2. It serves as a quick reference tool for the case manager during further contacts and visits with the client. The case manager is then able to accurately record the progress or lack of progress in the individual's record.
3. The Action Plan can guide necessary follow-up with others involved in the plan.
4. The Action Plan is beneficial for a case manager who may suddenly need to take over a case.

C. How does the Action Plan benefit the case management supervisor?

1. The Action Plan can serve as a quick supervisory tool for following the progress or lack of progress of a case.
2. The Action Plan can help the supervisor review how the case manager uses the data from the assessment to understand the clients' needs and then develop an appropriate plan.

Instructions

A. When do I complete the Action Plan?

The Action Plan is completed at the time of initial assessment and reassessment. All issues assessed as "priority" are included on the Action Plan. Progress, lack of progress, and changes in goals are recorded in the individual's file. Any significant change that triggers the need for a new assessment must also trigger the need for a new Action Plan.

B. How lengthy is an Action Plan?

1. The Action Plan should be as clear and concise as possible. It is not meant to be a narrative of the assessment. It should briefly address all major issues derived from the assessment. As many pages as necessary should be used to outline the major issues, goals and strategies.

C. Who receives the Action Plan?

1. The Action Plan has been developed on "No Carbon Required" (NCR) paper. The original copy is for the client, caregiver and/or family, the yellow copy is for the office file, and the pink copy is for the case record.

D. Who signs the Action Plan and where?

1. The Action Plan must be signed on the final page. Page numbers, such as Page 1 of 3 are recorded in the upper right hand corner of the document. The Action Plan is signed by the client or client representative and by the case manager. It is dated next to the client's name.

E. What is included under Issues and Goals?

1. All of the client's major issues and goals identified from the assessment are outlined. Issues and Goals (problems or needs) refer to the areas of concern identified from the assessment that require a plan of action. **Issues and Goals refer to what the client hopes to achieve through the Action Plan with the support of their caregiver(s) and/or family members, and case manager**. **The goals should be those of the individual receiving services**. If an individual does not agree to address an area of concern identified during assessment that can be noted on the plan as well. The status of the issues and goals should be recorded in the client record.
2. Example: Depression (Issue) Decrease signs and symptoms of depression. (Goal). You might even record a goal more specifically if it is the individual's goal. For example with depression it might be the individual's goal to be able to concentrate better, to have more energy, and/or to be able to take interest in pleasurable activities again.

F. What is included under plan/strategy?

1. Under Plan/Strategy the actions that will be taken to achieve the goal for each issue are outlined. There may be more than one action for each issue/goal. An example of a plan/strategy is: Referral to Elder Care Clinician for additional assessment and treatment.
2. The Status of the plan(s)/strategies should be documented in the client record.
3. Under Responsible Persons the person who will carry out **each** plan/strategy for **each** specific issue/goal is recorded. The "Responsible Person" may be the case managers, the provider, the client, family, caregiver and/or other formal/informal support people.

G. What is included under Target Date?

1. The Target Date refers to the time frame in which the "Responsible Person" hopes to achieve each specific plan/strategy for the issues/goals. The status of meeting the target dates should be recorded in the client record. Target dates should be as specific as possible, and not automatically default to "ongoing", or to a year-long timeframe (i.e.: 7/05-7/06), as a target completion date. If a goal really is an ongoing goal, then it is acceptable to use the annual review date as the completion date or in some cases "ongoing" if the goal is to maintain skills, but regardless, make sure to reassess the goal at the annual review.